CHAPTER V. AMBULATORY SURGERY DATA

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This section of the report presents information about ambulatory surgery collected from hospital-based ambulatory surgery programs and freestanding ambulatory surgery centers (FASCs).

Facilities that Reported Data

BHI collected ambulatory surgery data from 121 GMS hospitals and 32 FASCs during 2000. They submitted records on 632,011 patients (543,627 at hospitals and 88,384 at FASCs).

FASC Openings/Medicare Certifications

Aurora Medical Group Oshkosh – Surgery Center, Oshkosh, October 2, 2000

BayCare Surgery Center – East, Green Bay, July 2000

Eye Surgery and Laser Center, Milwaukee, October 2000

Wisconsin Health Center, Greenfield, February 9, 2000

FASC Closings

Oshkosh Surgery Center, Oshkosh, December 31, 2000

GMS Hospitals

For openings, closings, and special circumstances for GMS hospitals, see the table on page 37.

Selected Data Reported by Wisconsin Hospitals and FASCs

BHI collects data on all ambulatory surgery procedures performed in hospital-based outpatient surgery units and Medicare-certified FASCs. However, a significant number of ambulatory surgeries performed in Wisconsin are not included in BHI's database. This is because ambulatory surgeries are also performed in settings which are not required to submit data to BHI, such as FASCs that are not Medicare-certified, and clinics and urgent care centers that are not owned and operated by hospitals.

Charges in these reports represent the average amount billed for a surgical episode and are not necessarily the facility's routine charge for a particular type of surgery. Each record BHI collects contains a code for the principal procedure (the reason for the surgery) and codes for up to five other procedures. A patient who had multiple procedures should expect to have higher charges than one who had only one procedure.

The 20 procedures for which individual facility data are presented in this report are those principal procedures that were most frequently reported in 1999.

CPT-4 Codes vs. ICD-9-CM Codes

Hospitals and FASCs typically use different coding systems to report data to BHI. FASCs generally use CPT-4 procedure codes. Hospitals tend to use ICD-9-CM codes, although they may also use CPT-4 codes for Medicare patients, such as those undergoing cataract surgery.

The two coding systems are similar but not identical. For example, under CPT-4 coding, cataract removal and lens insertion can be reported as a single code; under ICD-9-CM coding, each step of the surgery must be reported as a separate code.

In order to present information on hospitals and FASCs together, it is necessary to convert the data into one common set of procedure codes. To do this, BHI uses computer software expressly designed to convert CPT-4 codes to ICD-9-CM codes.

How to Read The Ambulatory Surgery Tables

Summary Tables

The first part of the ambulatory surgery section presents data in the following summary tables:

- Table 25 presents the number of cases, the average charge and the quartile charges for 20 selected procedures (selected because they were the most frequently reported during 1999 by hospitals and FASCs in Wisconsin).
- Table 26 presents the age and sex distributions for patients undergoing these 20 procedures.
- Table 27 shows the expected primary pay sources for patients undergoing these 20 procedures.
- Tables 28-30 present the ICD-9-CM codes, number of cases, average charge, and total charges generated by the 40 most frequently reported ambulatory procedures, the 20 most expensive procedures (for which at least 5 cases were reported), and the 20 procedures generating the greatest amounts in overall charges during all of 2000.
- Table 31 sorts all the ambulatory procedures reported to BHI during 2000 into categories that describe the part of the body or system on which they were performed. The category Diagnostic/Therapeutic contains miscellaneous procedures not assigned to any of the other categories.

Comparison Group Tables

For each of the 20 selected surgical procedures, there is a table showing the number of cases, average charge per case, standard deviation, and the 25th, 50th, 60th, 70th, 75th, 80th, 85th, 90th, and 95th percentile distribution of charges statewide for all facilities, statewide for hospitals only, and statewide for FASCs only. The same data elements are presented for each three-digit ZIP code area in the state with hospital and FASC data combined. (See graphic on page 333.)

Facility-Specific Tables

For each procedure a table shows, by facility, the number of cases, average charge per case, standard deviation, and median charge. Data are sorted by three-digit ZIP code area and by city within each area. Hospitals and FASCs appear on the same tables, with an "H" designating a Hospital and an "F" a FASC. (See graphic on page 334.)

Facilities that reported fewer than three cases of a given procedure do not appear in the table for that procedure. However, their data are included in the statewide and ZIP code area totals. Facilities that reported three or four cases for a given procedure do appear in the table for that procedure; however, charge data are not provided, due to the small number of cases.

Comparison Group Tables

# of Cases is the number of cases for which this procedure was listed as the principal procedure.

Average Charge is calculated by totaling the charges for all patients assigned to the surgical category and dividing by the number of cases. It represents the amount, on average, a patient undergoing this type of ambulatory surgery was charged.

Standard Deviation is a measure of the average varaiation above or below the mean, or average, charge. When charges are in a normal distribution, approximately 68 percent of the cases will fall within one standard deviation of the mean, 95 percent within two standard deviations, and 99.7 percent within three standard deviations.

Percentile Charges mark the point above and below which some percentage of the patients' charges fall. For instance, half the patients were charged less than the 50th percentile, or median charge, and half were charged more. Similarly, 95 percent were charged less than the 95th percentile, and 5 percent were charged more.

ICD-9-CM Code 85.21: Local Excision of Lesion of Breast

January – December 2000

Note: Utilization and charge data are per surgical episode. They may include procedures other than the principal procedure.

	# OF CASES	AVERAGE CHARGE	STANDARD DEVIATION	PERCENTILE CHARGES								
				25TH	*50TH*	*60TH*	*70TH*	*75TH*	*80TH*	*85TH*	*90TH*	*95TH*
STATEWIDE DATA												
All Facilities	9,297	$2,679	$1,546	$1,684	$2,334	$2,608	$2,953	$3,202	$3,508	$3,864	$4,475	$5,658
FASCs	1,315	1,895	744	1,684	2,334	2,608	2,953	3,202	3,508	3,864	4,475	5,658
Hospitals	7,982	2,808	1,604	1,684	2,334	2,608	2,953	3,202	3,508	3,864	4,475	5,658
3 DIGIT ZIP CODE AREA DATA												
530**	953	$2,413	$1,615	$1,668	$1,827	$2,205	$2,608	$2,756	$2,979	$3,294	$3,763	$5,004
531**	708	3,209	1,904	1,815	2,833	3,337	3,884	4,425	4,871	5,396	6,028	6,757
532**								4,198	4,502	4,892	5,719	7,390
534**								2,458	2,696	2,976	3,303	4,393
535**								3,244	3,419	3,633	3,824	4,265
537**								2,346	2,591	2,845	3,260	4,214
538**								3,267	3,634	3,941	4,059	4,243
539**	340	2,307	1,115	1,543	1,996	2,166	2,611	2,781	3,070	3,442	4,153	4,690
540**	214	2,652	789	2,219	2,504	2,720	2,939	3,016	3,087	3,237	3,391	3,869
541**	293	2,267	841	1,745	2,164	2,294	2,491	2,584	2,646	2,817	2,926	3,279

The number of cases and the distribution of charges are summarized for the entire state and for each three-digit ZIP code area in the state. These figures include both hospitals and FASCs. Statewide data are also presented for hospitals only, and for FASCs only.

Facility-Specific Tables

ICD-9-CM Code (International Classification of Diseases, 9th Revision, Clinical Modification) is a coding system used by facilities, on patient records and billing forms, to designate which surgical procedure(s) were performed.

# of Cases is the number of cases at the facility for which this ICD-9-CM code was listed as the principal procedure. Facilities reporting fewer than three cases do not appear in the tables, although their data are included in the statewide and three-digit ZIP code area data. Facilities that reported three or four discharges do appear in the tables, but no charge data are presented for those cases.

Average (Mean) Charge is calculated by totaling the charges for all cases with this principal procedure and dividing by the number of cases. It represents the amount, on average, a patient assigned to this surgical category was charged.

Median Charge is the amount that half the patients were charged more than and half were charged less than.

Standard Deviation is a measure of the average variation above or below the average, or mean, charge. When charges are in a normal distribution, approximately 68 percent of the cases will fall within one standard deviation of the mean, 95 percent within two standard deviations, and 99.7 percent within three standard deviations.

ICD-9-CM Code 85.21: Local Excision of Lesion of Breast

January - December 2000

Note: Utilization and charge data are per surgical episode. They may include procedures other than the principal procedure.

BY FACILITY WITHIN 3 DIGIT ZIP CODE AREAS
(Excludes facilities with fewer than 3 cases)

		TYPE OF FACILITY	# OF CASES	AVERAGE CHARGE	MEDIAN CHARGE	STANDARD DEVIATION
530**						
Elmbrook Memorial Hospital	Brookfield	H	143	$3,700	$2,771	$2,916
Calumet Medical Center	Chilton	H	20	2,619	2,573	457
Hartford Memorial Hospital	Hartford	H	55	2,753	2,646	602
Community Memorial Hospital	Menomonee Falls	H	70	3,545	2,979	1,468
Menomonee Falls Amb. Surgery Center	Menomonee Falls	F	285	1,740	1,668	489
St. Mary's Hospital-Ozaukee	Mequon	H	94	2,187	1,753	1,517
Oconomowoc Memorial Hospital	Oconomowoc	H	61	2,628	2,511	974
Sheboygan		H	103	2,023	1,957	696
St. Nichol		H	19	1,813	1,490	900
Watertow		H	27	2,600	2,717	859
St. Josep		H	26	2,973	2,295	2,079
West Ben		F	50	1,328	1,480	525
531**						
Memorial Hospital Corp. of Burlington	Burlington	H	89	3,881	3,399	1,489
Lakeland Medical Center, Inc.	Elkhorn	H	109	2,252	2,230	536
Aurora Medical Center - Kenosha	Kenosha	H	62	4,525	4,661	1,562
Kenosha Hospital and Medical Center	Kenosha	H	114	3,550	3,527	1,961
Mercy Walworth Ambulatory Surgery Ctr.	Lake Geneva	F	8	3,800	3,811	153
Aurora Ambulatory Surgery Ctr.-Waukesha	Waukesha	F	27	916	822	212
Waukesha Memorial Hospital, Inc.	Waukesha	H	298	3,146	2,494	2,129
532**						
Children's Hospital of Wisconsin	Milwaukee	H	11	2,685	2,621	694
Columbia Hospital, Inc.	Milwaukee	H	179	2,997	2,393	1,989
Froedtert Memorial Lutheran Hospital	Milwaukee	H	170	5,486	4,411	2,710

Facilities are sorted by three-digit ZIP code area. Within each area, Facilities are sorted alphabetically by city. An "H" indicates the facility is a hospital; an "F" designates a FASC.

Table 25. Summary of selected ambulatory surgical procedure data, Wisconsin GMS hospitals and FASCs, 2000

ICD-9-CM Code	Procedure	Number of Cases	Avg. Charge	Percentile Distribution of Charges 25th	50th	75th
03.91	Injection of Spinal Canal for Analgesia	15,844	$649	$376	$586	$818
03.92	Injection of other Agent into Spinal Canal	20,732	610	408	551	750
04.43	Carpal Tunnel Release	10,519	1,892	1,275	1,741	2,353
13.41	Phacoemulsification and Aspiration of Cataract	27,118	3,310	2,511	3,192	4,063
13.59	Other Extracapsular Extraction of Lens	11,645	2,648	2,040	2,700	2,920
13.64	Discission of Secondary Membrane After Cataract	5,448	695	500	640	877
20.01	Myringotomy with Insertion of Tube	11,542	1,564	1,068	1,403	1,867
37.22	Left Heart Cardiac Catheterization	11,552	5,600	4,257	5,174	6,572
42.92	Dilation of Esophagus	6,741	1,228	818	1,091	1,437
45.13	Other Endoscopy of Small Intestine	11,814	1,026	705	852	1,146
45.16	EGD† w/Closed Biopsy	33,028	1,330	899	1,142	1,564
45.23	Colonoscopy	39,484	1,108	817	1,024	1,282
45.24	Flexible Sigmoidoscopy	16,730	519	241	373	672
45.25	Endoscopic Biopsy of Large Intestine	16,996	1,400	931	1,289	1,698
45.42	Endoscopic Polypectomy of Large Intestine	30,766	1,482	1,056	1,350	1,795
51.23	Laparoscopic Cholecystectomy	8,904	5,942	4,524	5,883	7,121
57.32	Other Cystoscopy	11,222	1,302	660	1,002	1,656
80.6	Excision of Semilunar Cartilage of Knee	13,473	3,800	2,702	3,465	4,513
85.21	Local Excision of Lesion of Breast	9,297	2,679	1,684	2,334	3,202
86.3	Local Excision/Destr. of Lesion or Tissue of Skin	20,687	892	173	393	1,279

Note: Charges may reflect charges for other ambulatory procedures performed during the same surgical episode. Refer to page 333 for an explanation of percentiles.

† Esophagogastroduodenoscopy

Source: Ambulatory Surgery Data, Bureau of Health Information, Division of Health Care Financing, Department of Health and Family Services.

Table 26. Age and sex distribution of persons undergoing selected ambulatory procedures, Wisconsin GMS hospitals and FASCs, 2000

ICD-9-CM Code	Procedure	Age Groupings 0-14	15-44	45-64	65+	Sex Male	Female
03.91	Injection of Spinal Canal for Analgesia	0.0%	28.9%	34.9%	36.2%	43.8%	56.2%
03.92	Injection of other Agent into Spinal Canal	0.1	29.5	34.4	35.9	44.4	55.6
04.43	Carpal Tunnel Release	0.0	35.7	40.0	24.3	37.7	62.3
13.41	Phacoemulsification and Aspiration of Cataract	0.1	1.4	14.1	84.4	36.4	63.6
13.59	Other Extracapsular Extraction of Lens	0.2	1.8	15.9	82.1	37.6	62.4
13.64	Discission of Secondary Memb. After Cataract	0.2	2.3	13.4	84.1	31.5	68.5
20.01	Myringotomy with Insertion of Tube	93.4	3.0	1.7	2.0	58.5	41.5
37.22	Left Heart Cardiac Catheterization	0.0	8.7	47.9	43.4	60.9	39.1
42.92	Dilation of Esophagus	0.8	18.7	34.3	46.2	51.3	48.7
45.13	Other Endoscopy of Small Intestine	1.0	32.0	34.3	32.7	40.5	59.5
45.16	EGD† w/Closed Biopsy	2.6	28.0	36.7	32.8	45.1	54.9
45.23	Colonoscopy	0.1	15.3	46.8	37.8	41.1	58.9
45.24	Flexible Sigmoidoscopy	0.1	12.5	53.2	34.2	48.2	51.8
45.25	Endoscopic Biopsy of Large Intestine	1.8	29.1	38.9	30.2	42.2	57.8
45.42	Endoscopic Polypectomy of Large Intestine	0.1	7.5	46.8	45.7	54.7	45.3
51.23	Laparoscopic Cholecystectomy	0.3	49.6	35.2	14.9	20.7	79.3
57.32	Other Cystoscopy	1.6	16.9	28.5	53.0	57.6	42.4
80.6	Excision of Semilunar Cartilage of Knee	0.8	37.9	47.0	14.3	59.5	40.5
85.21	Local Excision of Lesion of Breast	0.2	34.1	41.5	24.3	3.3	96.7
86.3	Local Excision/Destr. of Lesion/Tissue of Skin	7.6	33.5	29.5	29.4	47.3	52.7

Note: Rows may not total 100% due to rounding.

† Esophagogastroduodenoscopy

Source: Ambulatory Surgery Data, Bureau of Health Information, Division of Health Care Financing, Department of Health and Family Services.

Table 27. Expected primary pay source distribution of persons undergoing selected ambulatory procedures, Wisconsin GMS hospitals and FASCs, 2000

ICD-9-CM Code	Procedure	T18	T19	Other Gov't	Commercial Insurance	Self-Pay	Unknown
03.91	Injection of Spinal Canal for Analgesia	36.3%	3.0%	0.8%	58.7%	1.1%	0.0%
03.92	Injection of other Agent into Spinal Canal	36.3	2.7	0.5	58.0	0.8	1.7
04.43	Carpal Tunnel Release	24.5	3.5	0.3	70.4	0.7	0.6
13.41	Phacoemulsification and Aspiration of Cataract	81.4	0.9	0.2	17.0	0.5	0.0
13.59	Other Extracapsular Extraction of Lens	76.9	1.0	0.4	21.0	0.6	0.1
13.64	Discission of Secondary Membrane After Cataract	78.7	1.0	0.2	19.4	0.3	0.2
20.01	Myringotomy with Insertion of Tube	1.9	16.4	0.4	79.3	0.6	1.4
37.22	Left Heart Cardiac Catheterization	42.8	2.4	0.7	53.0	1.1	0.0
42.92	Dilation of Esophagus	47.1	2.1	0.4	49.3	0.8	0.2
45.13	Other Endoscopy of Small Intestine	34.5	4.4	0.7	58.5	1.3	0.6
45.16	Esophagogastroduodenoscopy (EGD) w/Closed Biopsy	33.6	4.3	0.7	59.9	1.0	0.5
45.23	Colonoscopy	37.2	1.6	0.5	59.7	0.7	0.4
45.24	Flexible Sigmoidoscopy	33.2	1.6	0.5	63.7	0.8	0.1
45.25	Endoscopic Biopsy of Large Intestine	30.0	2.5	0.6	65.3	1.0	0.7
45.42	Endoscopic Polypectomy of Large Intestine	43.9	1.3	0.4	53.6	0.5	0.3
51.23	Laparoscopic Cholecystectomy	15.6	5.8	0.7	75.5	1.9	0.5
57.32	Other Cystoscopy	51.6	3.2	0.7	43.5	0.7	0.2
80.6	Excision of Semilunar Cartilage of Knee	14.0	1.8	0.5	81.9	1.0	0.9
85.21	Local Excision of Lesion of Breast	24.4	3.2	1.0	69.0	1.4	0.9
86.3	Local Excision/Destruction of Lesion or Tissue of Skin	28.7	3.0	0.6	65.5	1.4	0.9

Note: Rows may not total 100% due to rounding.

T18 refers to Medicare. T19 refers to Medical Assistance.

Source: Ambulatory Surgery Data, Bureau of Health Information, Division of Health Care Financing, Department of Health and Family Services.

Table 28. Most frequently performed ambulatory surgical procedures, Wisconsin GMS hospitals and FASCs, 2000

ICD-9-CM Code	Procedure	Number of Cases	Average Charge	Total Charges
45.23	Colonoscopy	39,558	$1,108	$43,832,024
45.16	Esophagogastroduodenoscopy (EGD) w/Closed Biopsy	33,060	1,330	43,957,647
45.42	Endoscopic Polypectomy of Large Intestine	30,797	1,482	45,655,622
13.41	Phacoemulsification and Aspiration of Cataract	27,118	3,310	89,758,080
03.92	Injection of other Agent into Spinal Canal	20,885	609	12,719,626
86.3	Local Excision/Destruction of Lesion or Tissue of Skin	20,720	893	18,494,264
45.25	Endoscopic Biopsy of Large Intestine	17,022	1,400	23,833,421
45.24	Flexible Sigmoidoscopy	16,740	519	8,684,304
03.91	Injection of Spinal Canal for Analgesia	15,844	649	10,281,250
80.6	Excision of Semilunar Cartilage of Knee	13,517	3,800	51,365,227
13.59	Other Extracapsular Extraction of Lens	12,503	2,653	33,173,329
45.13	Other Endoscopy of Small Intestine	11,823	1,026	12,127,473
20.01	Myringotomy with Insertion of Tube	11,570	1,564	18,097,316
37.22	Left Heart Cardiac Catheterization	11,552	5,600	64,687,524
57.32	Other Cystoscopy	11,222	1,302	14,609,201
04.43	Carpal Tunnel Release	10,559	1,890	19,955,729
85.21	Local Excision of Lesion of Breast	9,324	2,675	24,940,511
51.23	Laparoscopic Cholecystectomy	8,921	5,939	52,985,656
42.92	Dilation of Esophagus	6,744	1,229	8,286,908
28.3	Tonsillectomy with Adenoidectomy	6,255	2,529	15,820,901
13.64	Discission of Secondary Membrane After Cataract	5,742	715	4,107,384
45.43	Endoscopic Destruction of Lesion/Tissue of Large Intestine	5,531	1,155	6,388,048
85.11	Closed (Percutaneous)(Needle) Breast Biopsy	4,534	1,466	6,647,161
04.81	Injection of Anesthetic into Peripheral Nerve for Analgesia	4,382	912	3,996,314
48.36	Endoscopic Polypectomy of Rectum	3,999	1,362	5,445,012
66.29	Bilateral Endoscopic Destr./Occlusion of Fallopian Tubes	3,659	3,338	12,212,214
81.92	Injection of Therapeutic Substance into Joint or Ligament	3,550	524	1,860,594
28.2	Tonsillectomy without Adenoidectomy	3,489	2,660	,281,212
69.09	Other Dilation and Curettage (D&C)	3,433	3,010	10,334,076
77.51	Bunionectomy with Osteotomy of the First Metatarsal	3,062	3,722	11,397,327
53.04	Repair of Indirect Inguinal Hernia w/Graft or Prosthesis	3,054	3,875	11,834,490
86.24	Chemosurgery of Skin	3,050	481	1,465,822
81.83	Other Repair of Shoulder	2,946	5,417	15,959,637
53.00	Unilateral Repair of Inguinal Hernia	2,781	2,966	8,247,270
82.21	Excision of Lesion of Tendon Sheath of Hand	2,654	2,144	5,691,267
83.63	Rotator Cuff Repair	2,621	6,148	16,114,095
53.49	Other Umbilical Herniorrhaphy	2,612	2,793	7,294,587
80.86	Other Local Excision or Destruction of Knee Lesion	2,569	3,586	9,211,370
57.49	Oth. Transurethral Excision/Destr. Lesion/Tissue of Bladder	2,562	3,102	7,946,686
53.03	Repair of Direct Inguinal Hernia with Graft or Prosthesis	2,444	3,900	9,532,489

Note: Charges may reflect charges for other procedures performed during the same surgical episode.

Source: Ambulatory Surgery Data, Bureau of Health Information, Division of Health Care Financing, Department of Health and Family Services.

Table 29. Most expensive ambulatory surgical procedures (with at least 5 cases reported), Wisconsin GMS hospitals and FASCs, 2000

ICD-9-CM Code	Procedure	Number of Cases	Average Charge	Total Charges
20.98	Implant/Replace Cochlear Prosthetic Device, Multiple Channel	6	$62,261	$373,563
37.94	Implant/Repl. Auto. Cardioverter/Defibrillator, Total System (AICD)	66	48,675	3,212,578
20.96	Implant/Replace Cochlear Prosthetic Device Not Otherwise Specified	27	36,722	991,489
37.96	Implantation Auto. Cardioverter/Defibrillator Pulse Generator Only	16	33,455	535,275
37.98	Replace Automatic Cardioverter/Defibrillator Pulse Generator Only	184	30,623	5,634,649
36.05	Multiple Vessel PTCA† w/wo/Mention of Thrombolytic Agent	134	22,969	3,077,842
04.92	Implantation or Replacement of Peripheral Neurostimulator	90	21,666	1,949,924
02.93	Implantation of Intracranial Neurostimulator	11	20,243	222,676
37.83	Initial Insertion of Pacemaker with Dual-Chamber Device	167	19,709	3,291,391
37.99	Other Operations on Heart and Pericardium	20	18,296	365,910
37.34	Catheter Ablation of Lesion or Tissue of Heart	595	17,667	10,511,631
36.06	Insertion of Coronary Artery Stent(s)	86	16,782	1,443,229
36.01	Single Vessel PTCA† wo/Mention of Thrombolytic Agent	526	16,622	8,742,960
36.02	1 Vessel PTCA† or Coronary Atherectomy w/Thrombolytic Agent	30	16,104	483,128
37.80	Insertion or Pacemaker, Initial or Replacement, Type not Specified	7	15,436	108,054
60.99	Other Operations on Prostate	16	15,344	245,512
37.72	Initial Insertion of Transvenous Leads into Atrium and Ventricle	63	15,196	957,373
92.27	Implantation or Insertion of Radioactive Element	372	15,139	5,631,887
37.81	Initial Insert. 1-Chamber Device not Specified as Rate Responsive	30	14,925	447,751
37.82	Initial Insertion of a Single-Chamber Device, Rate Responsive	24	14,433	346,392

Note: Charges may reflect charges for other procedures performed during the same surgical episode

†PTCA: Percutaneous Transluminal Coronary Angioplasty

Source: Ambulatory Surgery Data, Bureau of Health Information, Division of Health Care Financing, Department of Health and Family Services.

Table 30. Highest total charge-generating ambulatory surgical procedures, Wisconsin GMS hospitals and FASCs, 2000

ICD-9-CM Code	Procedure	Number of Cases	Average Charge	Total Charges
13.41	Phacoemulsification and Aspiration of Cataract	27,118	$3,310	$89,758,080
37.22	Left Heart Cardiac Catheterization	11,552	5,600	64,687,524
51.23	Laparoscopic Cholecystectomy	8,921	5,939	52,985,656
80.6	Excision of Semilunar Cartilage of Knee	13,517	3,800	51,365,227
45.42	Endoscopic Polypectomy of Large Intestine	30,797	1,482	45,655,622
45.16	Esophagogastroduodenoscopy (EGD) w/Closed Biopsy	33,060	1,330	43,957,647
45.23	Colonoscopy	39,558	1,108	43,832,024
13.59	Other Extracapsular Extraction of Lens	12,503	2,653	33,173,329
85.21	Local Excision of Lesion of Breast	9,324	2,675	24,940,511
45.25	Endoscopic Biopsy of Large Intestine	17,022	1,400	23,833,421
04.43	Carpal Tunnel Release	10,559	1,890	19,955,729
86.3	Local Excision/Destruction of Lesion or Tissue of Skin	20,720	893	18,494,264
20.01	Myringotomy with Insertion of Tube	11,570	1,564	18,097,316
81.45	Other Repair of the Cruciate Ligaments	2,163	7,951	17,197,387
39.50	Angioplasty or Artherectomy of Non-Coronary Vessel	2,048	8,093	16,574,644
83.63	Rotator Cuff Repair	2,621	6,148	16,114,095
81.83	Other Repair of Shoulder	2,946	5,417	15,959,637
28.3	Tonsillectomy with Adenoidectomy	6,255	2,529	15,820,901
37.23	Combined Right/Left Heart Cardiac Catheterization	2,368	6,599	15,625,876
57.32	Other Cystoscopy	11,222	1,302	14,609,201

Note: Charges may reflect charges for other procedures performed during the same surgical episode

Source: Ambulatory Surgery Data, Bureau of Health Information, Division of Health Care Financing, Department of Health and Family Services.

Table 31. Ambulatory surgical procedures, by major category, Wisconsin GMS hospitals and FASCs, 2000

Category of Surgical Procedure	Number of Cases	Total Charges
Cardiovascular	28,858	$184,600,564
CPT Codes Not Converted	222	377,122
Diagnostic/Therapeutic	8,851	27,037,776
Digestive	212,425	369,584,704
Ear	15,568	31,900,246
Endocrine	1,660	4,318,095
Eye	61,901	170,744,541
Female Genital	25,822	82,586,005
Hemic/Lymphatic	3,209	8,915,431
Integumentary	59,445	103,752,149
Male Genital	8,880	20,458,414
Musculoskeletal	80,840	293,067,928
Nervous	60,124	68,313,559
Nose/Mouth/Pharynx	27,860	76,457,254
Obstetrical	4,354	2,261,563
Respiratory	7,670	17,437,423
Urinary	24,322	54,653,530
Statewide Totals	632,011	$1,516,466,304

Source: Ambulatory Surgery Data, Bureau of Health Information, Division of Health Care Financing, Department of Health and Family Services.

Caveats/Data Limitations for Ambulatory Surgery Data

1. The ambulatory surgery utilization and charge data in this report are drawn from the federal billing form HCFA-1450 (UB-92) and/or the federal billing form HCFA-1500 as submitted by 121 GMS hospitals and 32 FASCs. The charge data taken from these forms have not been audited. **As a result, the charge data provided in this report may differ from audited financial data.**
2. The reported payment sources are based on first billings rather than actual revenue sources. Therefore, the reported distribution of payment sources in this report may differ from the actual distribution of payments collected.
3. Utilization and charge figures of ambulatory surgery data were not adjusted for severity, case mix, or any of a variety of other factors that could affect comparisons among facilities. All interpretations of actual data and all comparisons of one facility to another should be made with caution. In addition to case mix and severity, regional pricing differentials and variations in the types of services offered can affect levels of utilization or charges. Also, facility record-keeping and internal information systems vary in their levels of sophistication. This may affect the quality of the data submitted by individual facilities.
4. Each facility was asked to list one principal procedure and up to five secondary procedures per record for each surgical episode.
5. The charges listed in the text and tables are for each record in the database, not for individual procedures. A case may include more than one procedure. For example, a woman having a breast biopsy may also have an excision of other breast tissue or lab and x-ray procedures. Since comparisons should be made only between patients undergoing the same combination of procedures, more detailed information is required to enable a full comparison between patients and facilities. In addition, differences in facility billing practices may affect the distribution of charges. For example, a selected follow-up procedure to cataract surgery may be reported to BHI either as part of the basic surgical episode or as a separate episode.
6. Charge data for individual facilities are not listed if fewer than five procedures were reported. However, the data are included in the statewide figures.
7. The charges that facilities report for outpatient procedures exclude professional fees.

Ambulatory Surgical Procedures Used in the Report

The report provides in-depth coverage of the following 20 procedures:

Carpal Tunnel Release - ICD-9-CM code 04.43; CPT-4 codes 29848 and 64721: the surgical relief of pressure of the median nerve at the wrist. It is commonly performed on persons whose jobs require frequent repetitive hand motions (e.g., typing).

Colonoscopy - ICD-9-CM code 45.23; CPT-4 code 45378: a diagnostic procedure performed on the large intestine, using flexible fiber optics (excludes flexible sigmoidoscopy).

Dilation of Esophagus - ICD-9-CM code 42.92; CPT-4 codes 43220, 43226, 43248, 43249, 43450, 43453, 43456, 43458, and 43510: the stretching increase in the size of the caliber of the esophagus.

Discission of Secondary Membrane After Cataract - ICD-9-CM code 13.64; CPT-4 codes 66820 and 66821: rupture of the developed fibrotic lens capsule, following a previous extracapsular extraction or discission of the lens.

Endoscopic Biopsy of Large Intestine – ICD-9-CM code 45.25; CPT-4 codes 44100, 44389, 45331, and 45380: the removal of living large intestine tissue for microscopic examination by a closed technique. Colonoscopy with biopsy. Excludes proctosigmoidoscopy with biopsy.

Endoscopic Polypectomy of Large Intestine - ICD-9-CM code 45.42; CPT-4 codes 44392, 44394, 45308, 45309, 45315, 45333, 45338, 45339, and 45385: the excision of large intestine polyp performed by an endoscopic technique.

Esophagogastroduodenoscopy (EGD) with Closed Biopsy - ICD-9-CM code 45.16; CPT-4 code 43239: biopsy of one or more sites involving the esophagus, stomach, and/or duodenum.

Excision of Semilunar Cartilage of Knee - ICD-9-CM code 80.6; CPT-4 codes 27332, 27333, 29880, and 29881: the cutting repair of a crescent-shaped portion of the knee joint cartilage. The procedure facilitates knee joint motion hampered by excess cartilage growth.

Flexible Sigmoidoscopy - ICD-9-CM code 45.24; CPT-4 code 45330: endoscopy of the descending colon.

Injection of Other Agent into Spinal Canal - ICD-9-CM code 03.92; CPT-4 codes 62288, 62289, 62298, and 96450: injection of a steroid drug or refrigerated saline into the subarachnoid space.

Injection of Spinal Canal for Analgesia - ICD-9-CM code 03.91; CPT-4 codes 62310, 62311, 62318, and 62319: injection of diagnostic or therapeutic substances including anesthetic, antispasmodic, optoid or steroid.

Laparoscopic Cholecystectomy - ICD-9-CM code 51.23; CPT-4 codes 56340-56342: the removal of the gallbladder performed by a laparoscopic technique.

Left Heart Cardiac Catheterization - ICD-9-CM code 37.22; CPT-4 codes 93510, 93511, and 93514: the insertion of a cardiac catheter into the left heart chambers for the detection or cardiac abnormalities.

Local Excision of Lesion of Breast - ICD-9-CM code 85.21; CPT-4 codes 19112, 19120, 19125, 19126, and 19371: the cutting removal of damaged breast tissue, includes lumpectomy.

Myringotomy with Insertion of Tube - ICD-9-CM code 20.01; CPT-4 codes 69433 and 69436: incision of the eardrum with insertion of a hollow tube for drainage.

Other Cystoscopy - *ICD-9-CM code 57.32; CPT-4 code 52000*: the optical instrumental examination of the bladder, other than through an artificial stoma.

Other Endoscopy of Small Intestine - ICD-9-CM code 45.13; CPT-4 codes 43235 and 43241: the optical instrumental examination of

the small intestine, other than inserted through the abdominal wall or an artificial stoma.

Other Extracapsular Extraction of Lens - ICD-9-CM code 13.59; CPT-4 codes 66940 and 66984: removal of the lens of the eye, leaving the posterior capsule intact.

Other Local Excision or Destruction of Lesion of Skin and Subcutaneous Tissue - ICD-9-CM code 86.3; CPT-4 codes 11050-11052, 11200, 11201, 11300-11303, 11450, 11451, 11462, 11463, 11470, 11471, 15000, 17000-17002, 17010, 17100-17102, 17104-17108, 17110, 17200, 17201, 17250, 17260-17264, 17266, 17340, 21555, 23075, 24075, 25075, 26115, 27047, 27327, 27618, and 28043: the cutting removal or forcible death of damaged or other skin and subcutaneous tissue.

Phacoemulsification and Aspiration of Cataract - ICD-9-CM code 13.41; CPT-4 code 66850: removal of the lens of the eye, leaving the posterior capsule intact, using sound waves to liquefy the lens substance before withdrawal by suction.